	Western Regional Advisory Committee (RAC) Meeting September 24, 2008 Minutes 5:00 p.m. - 7:00 p.m. Four Points by Sheraton Hagerstown	
Agenda Item	**Discussion**	**Decisions/Follo w-up**
Welcome • Introduction of AIDS Administration Staff and Participants	• Claudia Gray welcomed everyone to the meeting. • Introductions occurred.	N/A
RAC Update • Overview of RAC • Meeting Purpose • Summary of Evaluation Responses	• Jennifer Taylor Gray and Maureen Blanco discussed the reason for RAC meetings and encouraged continued participation. • Jennifer Taylor Gray reviewed the evaluations from the May meeting.	N/A
Re-Visit Brainstorming from May Meeting • Summary of Responses	• Claudia Gray reviewed the brainstorming session from the May meeting about recruitment of new participants.	N/A
Recruitment Brochure • Packet Content Presentation • Recruitment Commitment	• Claudia Gray reviewed the new RAC/AIDS Recruitment brochure and encouraged meeting attendees to share them with potential recruits.	N/A
Community Dialogue • Process Description • Small Group Facilitators	• Glenn Clark presented a Community Input slideshow that explains the importance of feedback from the clients/community. He also explained the benefits of the information and input given by those groups. • Carmi Washington-Flood broke the attendees into group discussions to review 4 topics related to the issues the organizations and clients are facing in trying to better plan, outreach, and gain efficiency in working towards their common goals.	N/A
Wrap Up • Completing	• Announcements were made and Evaluations were distributed and collected. • 32 attended the meeting today	Evaluation results will be

Evaluations • Announcements • Next Steps	• The next Western RAC meeting is October 22, 2008 at the Washington County Health Department 10:00 a.m. - 12:00 p.m. • Meeting adjourned at 6:55p.m.	shared in the future.

Childcare Payment Requests: 0
Travel Expense Requests: 4

Western RAC Community Input

Case Management	Substance Abuse	Prevention	Medical Care
Barriers/Gaps • Empowerment-still • Adherence has improved-still issue with substance abusers • Referrals still and issue-going better in some areas • Transportation • Funding • HIV as decreasing priority • C.M. not culturally diversified not understanding issues, not same demographics • No positive self management in rural areas • C.M. burnout in some areas • Housing • Language barrier-Hispanics in Frederick Co also French in W. MD, Russian • Expecting that C.M. will do everything	**Trends** • Meth clinics are full – Alleg county • Wash County increased heroin use • Lack of Addictions care - Alleg. • Lack of Spanish speaking services • Meth clinics not testing for HIV Alleg. & Wash. Counties • Wash. County 80% currently or history of serious drug abuse • Frederick county serious drug abuse • Garrett County without clinics – most travel to Alleg. • Increased heroin use in Wash. • Fred. – No new trends since 2005 • Garrett County no Meth treatment • Alleg. County increased violence related to drugs • Fred., Wash. No HIV testing • Lots of unprotected sex • More babies • Prisoners having sex with women in community **Barriers/Gaps** • Language • Not enough services • Confidentiality • NA & AA Groups not conducive to	**Trends:** • Nurses-trained to do CTR • Streamlining testing process • Outreach from RAC meetings • All the recruitment being done. • Education awareness increasing • Fewer educational programs within schools • More young MSM **Barriers/Gaps:** • Most facilities are immobile (people don't want to come to HD) • People want to keep their business private • Funding: testing, outreach, and not enough prevention • Stigma • No support groups in some countries • Not enough testing in some regions • Not enough trained staff to test-bureaucracy/admin stuff keeping volunteers from helping • Prevention has not achieved original goals.	**Barriers/Gaps:** • Stigma-not getting into care • Fear of disclosure • Rural areas different • Those who have money go out of town • Lack of choice • Confidentiality • Some MD's still not reporting • The more rural the counties have more concerns • Funding • Insurances • Those with eligibility issues PCP hesitate to treat anything • Increase case loads for C.M. • Access to insurance providers-some have to go out of area to find provider • Communication • Need for translators • Lack of time, vs. lack of knowledge • Lack of effective way to contact clients (i.e. phone

will do everything • Increasing workloads • Decreasing resources and funding • Increasing needs • Volunteers not being utilized • Dealing with insurances • Increasingly ill clients • Clients with no insurance • No positive self management programs in some regions (Western Regions) • Need to increase literature • Need current literature • Some HIV + not in care • Limited staffing • Not enough time • Caseloads exceed internal policy • Local HD cannot give care funding • Lack of faith-based programs **Successes:** • Local C.M. are increasing quality of care • Support group clients doing own research with guidance from HD	dealing with HIV • Transportation for folks in County • Transportation stops at night in the City • No system for addition care, Wash. • No system for mental health care – Frederick and Wash. County • Client has to want it • Addictions are a barrier to treatment • Waiting for services • Location know as treatment/meeting center • How treatment centers handle outings (privacy) • Treatment (out patient) not doing HIV testing • Recognition by staff in small co's • Did not go to support groups for fear of recognizing other members • Would not want to divulge HIV status at drug Tx facility – (stigma) • Distance to services & CTR's • Transportation • Accessing services/CTR's • Additions counselors do not know much about HIV • Accessing in pt care full of red tape • Clients remaining adherent in in-pt programs • Hospitals won't detox • Double stigma (drug & HIV diag.) • Small communities (privacy) • Detention center confidentiality • Cultural diversity • Sub. Abuse issues have erection	• Lack of resources—who will provide them? • Confidentiality • Can't talk about it in schools • Not enough being tested and the ones who are mostly know they don't have it • Not enough volunteering • Fear-they don't want to know • Denial—getting in the way of being tested • There is a belief that it is fixable-invincible • People don't talk about erections-not enough condom usage. • Medication working is causing a decline in prevention • Young people think disease has gone away or passed. • People being tested are already sick • Transportation • PC providers don't want to take some insurances in turn don't take clients **Successes:** • Mobile testing facilities • Collaboration between health dept. and other testing facilities • People feel more comfortable • CTR form was shortened • Streamlined consent process • Use of rapid testing • Increased availability in testing	cards run out) • Locating the client • Lack of dental care • Use of University of MD dental • Caseload of ID Doctors overloaded • MA providers • Lack of providers • Need for government health care and dental • Hep C treatment-Frederick Co clinic-private clinic • Transportation • Addictions **Solutions:** • Medical care yellow pages resource guide • Location • Break through flow of clinic • Someone local to provide care • More client advocacy • Need to advertise-put out information to clinics, PCP, etc. brochures • New laws • Confidentiality • Increased education to those PCP "trying to treat HIV" • Refer to specialist • Reduce neg. association of HIV and sex, drugs • Keep talking about it • Putting a face to HIV

staff • Very good teams in some areas • C.M. is rewarding **Suggestions:** • More advocacy programs and volunteers • More support groups • More funding • Define roles of C.M. • NSG roles • New literature automatically sent to C.M.'s • Training/better training for C.M.'s • Help with navigating insurance issues, eligibility issues • Distribute $ differently • Better collaboration with DSS	issues • Hard to put a condom on without an erection • "I want help as long as I don't have to change • Education – Commitment • Not getting care they need till they hit bottom • Lack of needle exchange programs **Solutions** • Mental Health & Additions services housed within case mgt. and free • More Spanish speaking • Detox in Fred., Wash and Alleg. • Buses/mobile services • HIV education, testing, & literature in all facilities: mandated • More weekend hours, after hours care, evenings • Support groups within CM prog. • Need more resources • Education of CMs • Advertisement • Going into prisons • Educate youth • Link ERs with Tx programs • De-stigmatize Sub. Abuse and mental health	• Abstinence education is the only funded program **Solutions:** • Increase mobile testing facilities and expand to other areas • More support groups • More funding for staff and overall goals • Increase awareness within schools and other educational facilities • Use mass media to outreach • Trained volunteers • Back to putting a face on HIV/AIDS • Role models speaking/educating • More discussion of virus transmission • Increase in mental health and addiction services • Having someone accountable for these things • Involving community • Education for physicians about testing, results, and prevention • More specialists • More money	• Network CM, MD, pharmacy • Create empathy • Doctors need to take more time to explain meds, side effects, etc. procedures • Have a centralized means to voice complaints • Hotline # • Recruit younger MD's • Need to expand access to HIV care

Anonymous responses taken from the Index Cards:

- "Washington County staffing caseload increase only – FTE 2.1"
- "AIDS Administration to send POS and A&U Magazines to each co. CM Program – Clients want."